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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

State of Louisiana ex rel. RICHARD P. IEYOUB,
Attorney General,
Petitioner,

v.

CIGNA HEALTHPLAN OF LOUISIANA, INC., and
CONNECTICUT GENERAL LIFE INSURANCE CO.,
Respondents.

On Petition For A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND AETNA INC.

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BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND AETNA INC.

INTEREST OF *AMICI CURIAE*

Amicus the National Association of Manufacturers ("NAM") is the nation's oldest and largest broad-based industrial trade association. Its more than 14,000 member companies and subsidiaries, including approximately 10,000 small manufacturers, are located in every State and produce roughly 85 percent of U.S. manufactured goods. Through its member companies and affiliated associations, NAM represents every industrial sector, 185,000 businesses and more than 18 million employees. The overwhelming majority of NAM member companies sponsor health benefit programs for their employees, and most of these programs use some form of managed care.

Aetna Inc., through its health-related subsidiaries, is one of the Nation's largest administrators of managed health care programs. Aetna has created and maintains managed care networks, including preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"), in Louisiana and throughout the country. Aetna provides structured health care programs and administrative services to thousands of employers, representing approximately 16 million managed care members nationwide. In Louisiana, more than 100,000 individuals receive treatment through an Aetna-administered managed care program, including more than 40,000 in Aetna PPOs and almost 35,000 in HMOs.

As employee benefit plan sponsors and administrators, *amici* have a vital interest in maintaining cost-effective quality health care for plan participants. Managed care is critical to achieving this goal. Statutes like LA. REV. STAT. § 40:2202(5)(c), the Louisiana any willing provider law at issue in this case, undermine the fundamental principles of managed care by constricting the ability of plan administrators to control managed-care networks. As a result, enforcement of such laws in other States imposes damaging constraints on employee benefit plans, directly contrary to the purpose of ERISA, which was intended to free employee benefit plans from the often stifling and costly restrictions imposed by widely varying and inconsistent state regulation. The parties have consented to the filing of this *amicus* brief.

DISCUSSION

This case presents the question whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts so-called "any willing provider" laws that prevent preferred provider organizations ("PPOs") and similar

managed-care networks from limiting the number of health care providers that are members of such organizations. That question has divided the state and federal appellate courts, with the result that ERISA plan providers and administrators are being subjected to conflicting requirements and inconsistent degrees of federal protection in different jurisdictions across the country.

Moreover, the question presented in this case is of extraordinary importance for the economically efficient delivery of health care to employee benefit plan participants across the Nation. The Louisiana any willing provider law at issue in this case (LA. REV. STAT. § 40:2202(5)(c)), like similar statutes in other States across the country, severely restricts the ability of employee benefit plan administrators to control provider membership in managed-care networks. In so doing, these statutes undermine the fundamental economic logic of managed-care arrangements and threaten to destroy the promise of managed health care to achieve widely available cost-effective medical treatment. In short, these statutes subject employee benefit plans to precisely the kind of inconsistent and inefficient regulation that ERISA was intended to preempt.

Absent plenary review by this Court, low-cost and innovative health care options will continue to be stifled on a haphazard basis in many States as the lower courts continue to reach inconsistent results on the question whether ERISA preempts any willing provider laws. *Amici* urge the Court to grant plenary review of the petition's first question in order to ensure a consistent nationwide solution to this important and pressing question.[1]

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[1] The second question presented in the petition is not worthy of review. Petitioner does not and cannot contend that

I. THIS CASE PRESENTS AN IMPORTANT FEDERAL QUESTION THAT SHOULD BE RESOLVED BY THIS COURT

The efficient delivery of health care is an intractable problem; solutions will require ingenuity, experimentation, and flexibility. ERISA encourages these solutions through its broad preemption provision, which is intended to relieve employee benefit plans of the burden of compliance with state regulation. *E.g.*, *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1677 (1995); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Among other things, ERISA precludes any state regulation that interferes with attempts to provide efficient delivery of health care to employee benefit plan participants. Any willing provider laws fall squarely into this category.

ERISA preemption establishes employee benefit plan regulation "as an area of exclusive federal con-

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the second question involves a circuit conflict, and the court of appeals' ruling on that issue is wholly consistent with, and indeed compelled by, binding precedent of this Court. *E.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983). This Court's decision in *Seminole Tribe of Fla. v. Florida*, 116 S. Ct. 1114 (1996), is not to the contrary. That decision holds only that injunctive relief is inappropriate "where Congress has prescribed a *detailed remedial scheme* for the enforcement against a State of a *statutorily* created right." 116 S. Ct. at 1132 (emphasis added). No such detailed scheme exists here, and respondents sought enforcement of the Supremacy Clause, not merely a statutory right. Moreover, *Seminole Tribe* expressly reaffirms that litigants "may obtain injunctive relief under *Ex parte Young* in order to remedy a state officer's ongoing violation of federal law." *Id.* at 1131 n.16; *see also id.* at 1133 n.17.

cern." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). ERISA preempts not only state laws on subject matters covered by ERISA, but also all state laws that have any "connection with or reference to" an employee benefit plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); *Travelers*, 115 S. Ct. at 1677. ERISA occupies the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Shaw*, 463 U.S. at 98-99. The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the discretion of benefit plan designers and labor-management negotiations. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Health care is one such area. ERISA places few restrictions on the delivery of employee welfare benefits, like health care, allowing instead for broad-ranging innovation and ready adaptation to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081(1) (exempting welfare plans from funding requirements applicable to pension plans). "[M]edical insurance must take account of inflation, changes in medical practice technology, and increases in the cost of treatment independent of inflation." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). ERISA leaves health care plan administrators free to do just that.

Any willing provider laws like the statute at issue in this case effectively tie the hands of plan administrators and threaten to preclude employee benefit plans from offering health benefits through PPOs. These managed-care arrangements are precisely the type of market-driven innovation that Congress intended to encourage through enactment of ERISA. *See Moore v.*

Reynolds Metals Co. Retirement Program, 740 F.2d 454, 456 (6th Cir. 1984) ("decisions [concerning plan benefits] are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation"), *cert. denied*, 469 U.S. 1109 (1985). The destructive effects of any willing provider laws on PPOs underscore the extraordinary importance of this case to the efficient delivery of health care.

The PPO is a mechanism by which employee benefit plans deliver health care to plan participants at reduced cost. The cost savings afforded by a PPO are made possible by ensuring increased patient volume for preferred providers. PPO administrators customarily contract with a limited network of "preferred" health care providers for the provision of health care services to employee benefit plan participants. Employee benefit plan participants who choose PPOs are given financial incentives to use preferred rather than nonpreferred providers; participants typically are reimbursed for a greater percentage of the cost of treatment by a preferred provider. This practice results in a relatively greater number of patients for preferred providers. Increased patient volume allows the preferred providers to lower their per-patient costs, which, in turn, permits the providers to discount their fees. The promise of increased patient volume also creates price competition among providers, to the benefit of plan participants. *See, e.g.*, Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A "Green Light to the Gold Rush"?*, 41 SW. L.J. 1155, 1187-1190 (1988); G.A. Melnick, *et al.*, *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992).

Some limitation on PPO provider membership is thus necessary to enable the preferred providers to receive an increase in patient volume sufficient to warrant the reduction in fees. *HCA Health Services of*

Virginia, Inc. v. Metropolitan Life Ins. Co., 752 F. Supp. 202, 204 (E.D.Va. 1990) ("The exclusion of some providers is a necessary prerequisite of a limited provider network. It is by limiting the number and types of providers included in a PPO that a [PPO administrator] is able to implement cost reductions in services for health beneficiaries."), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992). The broader the PPO network, the less likely it is that the preferred providers will each experience the increase in patient volume necessary to permit cost reductions.

Limited provider networks are beneficial in other ways as well. PPO administrators can lower costs and improve the quality of medical care by eliminating unnecessary treatment. Pre-utilization review, monitoring of provider practices, and provider education all make health care utilization more effective and efficient. But it becomes more difficult and expensive for plan administrators to provide such service to plan participants as the number of providers in the network increases. General administrative expenses associated with the processing and payment of claims also increase as plan administrators must deal with more providers. *See* John F. Sheils, David C. Stapleton & Randall A. Haught, THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES: THE COST TO GOVERNMENTS, EMPLOYERS AND FAMILIES 3-4, 14-15 (Lewin-VHI 1995). A limited PPO network means more savings and better health care for plan participants.

The cost savings made possible by the PPO option are substantial. A recent study of employee health plan data found that health spending for participants in PPO plans was about 11 percent less than in traditional fee-for-service plans due to a combination of price discounts and utilization controls. David C. Stapleton, NEW EVIDENCE ON SAVINGS FROM NETWORK MODELS

OF MANAGED CARE 4 (Lewin-VHI 1994). The Congressional Budget Office has reported that national spending for health care grew about 6 percent in 1994, the slowest rate in 30 years, in part due to a dramatic increase in managed care programs, including PPOs and health maintenance organizations ("HMOs"). Congressional Budget Office, THE ECONOMIC AND BUDGET OUTLOOK: AN UPDATE 82-83 (1995).

Any willing provider laws undermine these salutary effects by mandating the unlimited expansion of PPO provider membership. These laws therefore increase dramatically both the cost of administration and the cost of claims made by employee benefit plan participants. One recent study concluded that if a national any willing provider law had been enacted in 1995, it would have increased private sector health spending by almost $75 billion through the year 2002. THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES at 25. It is not surprising that a 1986 survey of PPO sponsors found that mandatory provider statutes -- a variant of any willing provider laws -- posed the most serious of all possible regulatory threats to the effective operation of PPOs. Elizabeth S. Rolph, Paul B. Ginsburg & Susan D. Hosek, *The Regulation of Preferred Provider Organizations*, 6 HEALTH AFFAIRS 32, 40 (Fall, 1987).[2]

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[2] Any willing provider laws pose the same threat to HMOs, another form of managed care. HMOs contract with participating health care providers in a number of ways -- including independent contracting with individual physicians, contracting with medical group practices or associations of physicians, or direct employment of physicians -- but the fundamental economic logic of the HMO, and the basis for the substantial savings it generates, are the same as those of a PPO: each benefits from a limited provider network. To varying extents, HMOs differ from PPOs in that the purchaser of medical services from an HMO, typically a benefit plan

These increased costs will be felt by plan participants in the form of higher deductibles and copayments, and by plan sponsors who foot most of the bill for employee health care. This burden only adds to the strain that escalating employee health care liability already imposes on employers. By exacerbating the health care crisis, any willing provider legislation imposes a significant drag on the economy.

The federal government has recognized that any willing provider laws also impair competition among health care providers, to the detriment of consumers. The Federal Trade Commission has for over a decade objected to mandatory provider laws as anticompetitive and anticonsumer. Attached (App., *infra*, 1a-10a) is a 1993 letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana. The letter details the FTC's objections to Montana's any willing provider statute, reaffirming all of the cost and competition effects discussed above. The Acting Director explains the competitive importance of limited-provider

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sponsor, generally pays on a capitated basis (*i.e.*, the sponsor pays a fixed fee to the HMO for each participant in the plan), rather than on the discounted fee-for-service basis that is the norm for PPOs. Another important distinction is that the HMO network is usually exclusive: plan participants enrolled in an HMO must use an in-network provider if they are to receive any benefits at all. This obviously creates powerful incentives for all participants to use HMO providers, and increases the HMO administrator's ability to extract price discounts from competing health care providers seeking the HMO business. In addition, all of the utilization control and administrative cost savings associated with limited PPO networks apply to limited HMO networks as well. To the extent any willing provider laws can be read to apply to HMOs, their destructive effects are multiplied.

panels and the anticompetitive, anticonsumer effect of any willing provider requirements. The letter also describes the FTC's long-standing public objection -- expressed through congressional testimony, comment letters to state legislators and agencies, and litigation[3] -- to efforts to suppress selective contracting with a limited panel of health care providers. The FTC's opposition to any willing provider laws underscores the importance of the issue in this case to health care consumers.

Any willing provider laws unduly restrict the ability of employee benefit plan administrators to construct health care arrangements for the benefit of plan participants. The Louisiana statute at issue in this case, for example, precludes flexibility in plan structure and instead imposes a particular mechanism for provider selection, whereby a plan administrator first must establish a set of "terms and conditions" for network participation. LA. REV. STAT. § 40:2202(5)(c). Left to its own judgment, however, a managed care plan might choose not to establish a uniform set of terms and conditions for network participation. Indeed, it is probably more efficient not to do so. A plan administrator often can achieve better service and lower cost by negotiating with providers or groups of providers on an ad hoc basis. By pitting health care providers

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[3] The FTC has instituted a series of law enforcement actions to prevent private anti-competitive arrangements that suppress or eliminate selective contracting. *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988). *See generally* App., *infra*, 2a-3a. These private arrangements have the same deleterious effects as any willing provider laws.

against one another in market-driven competition for plan business, a plan administrator can often extract price discounts. *See Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc.*, 784 F.2d 1325, 1343 (7th Cir. 1986) (requiring plans to offer the same price to all providers "would make hash of the idea of a PPO. . . . The requirement that [providers] bid in order to get the plan's business is the principal source of the incentive to cut costs, and the prospect of getting more business by becoming a 'preferred' provider is the principal benefit to the [provider].").

Moreover, providers differ widely in the package of goods they can offer plan participants, including range of services, quality of care, geographic access, and general availability. A prudent plan administrator will consider all these factors in deciding whether, and under what conditions, to include a provider or group of providers in a PPO network. *See* THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES at 18.

While the decision below properly holds that any willing provider laws are preempted, and thereby avoids the deleterious effects discussed above, the Fifth Circuit's ruling is binding in only three States. Unfortunately, any willing provider laws and analogous statutes have been adopted in numerous States across the country.[4] Absent review by this Court, many of those

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[4] The Louisiana any willing provider law is part of an alarming recent trend toward mandatory-provider legislation. Several States impose a requirement that any provider willing to meet the terms and conditions of a PPO must be allowed into the network. *E.g.*, GA. CODE ANN. § 33-20-16; 215 ILL. COMP. STAT. ANN. § 5/370h; IND. CODE ANN. § 27-8-11-3; VA. CODE §§ 38.2-3407, 38.2-4209; WYO. STAT. § 26-22-503; *see also* UTAH CODE ANN. § 31A-22-617. The any willing provider requirements in some States apply to all health

laws will continue to hinder the ability of ERISA plan administrators to offer low-cost managed health care options to plan beneficiaries and will thwart Congress's intent to foster innovation and flexibility in the provision of employee benefits. Accordingly, the question presented in this case is one of exceptional importance, and review by this Court is necessary.

II. THE COURT OF APPEALS' DECISION IS INCONSISTENT WITH THE DECISIONS OF OTHER STATE AND FEDERAL APPELLATE COURTS

Section 514(a) of ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). Under ERISA Section 514(b)(2)(A), however, "any law of any State which regulates insurance" is saved from preemption. 29 U.S.C. § 1144(b)(2)(A). For purposes of applying this insurance savings clause, the statute makes clear

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care providers, while in other States the law excludes institutional providers. *E.g.*, 215 ILL. COMP. STAT. ANN. 5/370h; LA. REV. STAT. ANN. § 40:2202(5)(c). In still other States, the law applies only to pharmacy arrangements. E.g., ALA. CODE § 27-45-3; IDAHO CODE § 41-1844; S.D. CODIFIED LAWS ANN. § 58-18-37; TEX. INS. CODE, art. 21.52B. And numerous States mandate inclusion of certain types of providers (*e.g.*, chiropractors or podiatrists). *E.g.*, KAN. STAT. ANN. §§ 40-2,100, 40-2,101; MO. REV. STAT. §§ 354.027, 375.936(11)(b); NEB. REV. STAT. § 44-4112; NEV. REV. STAT. ANN. §§ 695C.177, 695C.178; W.VA. CODE § 33-25A-31. Overlaid on these disparate statutory requirements are regulations in the various States that may impose additional requirements or otherwise give specific meaning to the often indeterminate language of statutes. *E.g.*, Ark. Ins. Comm. Bulletin 9-85 & 9-85A (1985) (interpreting Arkansas statute as an any willing provider law).

that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance." ERISA §514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

In this case, the court of appeals correctly held that a State's attempt to impose an any willing provider requirement on entities establishing or offering PPO networks "relate[s] to" employee benefit plans and is not saved from preemption by the insurance exception. By contrast, a number of other appellate courts have reached the opposite result in the same or similar contexts. As the law currently stands, therefore, benefit plan administrators face burdensome any willing provider requirements in some jurisdictions, yet are immune from precisely those same requirements in other jurisdictions. This clear conflict in the scope of ERISA preemption merits plenary review.

At least one appellate court has issued a decision that conflicts with the court of appeals' correct determination that statutes regulating PPO membership "relate to" employee benefit plans for purposes of ERISA preemption. In *Napoletano v. CIGNA Healthcare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996), the Supreme Court of Connecticut held that the State's managed care statute did not "relate to" employee benefit plans and was therefore not subject to ERISA preemption. *Id.* at 136-45. The court reached this conclusion despite the fact that the Connecticut statute requires PPO networks to file with the State their criteria for selecting health care providers, and then grants health care providers and ERISA plan participants the right to sue over the exclusion of providers from the networks. *Id.* at 130 n.3, 144-45, 146.

This holding, and the reasoning supporting it, are directly inconsistent with the decision of the court of appeals in this case. The *Napoletano* court based its narrow reading of the "relate to" clause on *New York*

State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1996), which (according to the *Napoletano* court) mandates a "retreat[] from" this Court's previously expansive view of ERISA preemption. 680 A.2d at 140. The court below, by contrast, relied on "the limited nature of [the] holding" in *Travelers* to conclude that statutes regulating the membership of ERISA plans' PPO networks necessarily "relate to" those plans within the meaning of ERISA's preemption provision. Pet. App. 13a.

As a result of this disagreement over the scope of the *Travelers* decision, these courts reached diammetrically opposed results on the question whether a state law "relate[s] to" ERISA plans if it purports to regulate the ability of PPOs offered by ERISA plans to exclude health care providers from their networks. *See also Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.) (holding that an any willing provider law "relate[s] to" employee benefit plans), *cert. denied*, 510 U.S. 1003 (1993). This conflict over the meaning of "relate to" and the impact of this Court's *Travelers* decision by itself warrants certiorari review.

In addition, several appellate courts have incorrectly held (in contrast to the decision below) that any willing provider statutes or analogous state laws are saved from ERISA preemption by virtue of ERISA's insurance savings clause. In *Stuart Circle Hosp. Corp.*, *supra*, for example, the Fourth Circuit upheld a Virginia statute that requires insurers (including insurers acting as third-party administrators of employee benefit plans rather than as providers of traditional health insurance) to admit all willing providers to their PPO networks. 995 F.2d at 502-04. The court conceded that this any willing provider statute "relates to" employee benefit plans and that "facially the statute only directly affects providers" rather than insureds, but

nonetheless held that the statute was saved from preemption as "a law regulating the business of insurance." 995 F.2d at 502, 504.

Similarly, the Tenth Circuit in *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), rejected an ERISA preemption challenge to a Kansas "mandated-provider" statute. The Kansas statute required employee benefit plans offering health insurance benefits to cover services provided by all members of a specified class of health care providers. *Id.* at 1333. The court held that the mandated-provider law regulated "the business of insurance" and was therefore not preempted (*id.* at 1334-36), even though the effect of the statute was to expand the ability of health care providers (who are plainly *not* engaged in "the business of insurance") to receive reimbursement from employee benefit plans.

In *Blue Cross & Blue Shield of Va. v. St. Mary's Hosp. of Richmond, Inc.*, 426 S.E.2d 117 (Va. 1993), the Virginia Supreme Court addressed an ERISA preemption challenge to an any willing provider statute that applied to PPOs offered by nonstock corporations. *Id.* at 118. Applying what it characterized as the "common-sense" approach articulated by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Virginia court concluded that this any willing provider law "'regulates insurance' within the meaning of ERISA's exception to its preemption clause." 426 S.E.2d at 122. Accordingly, the court held that the statute was not preempted by ERISA. *Id.* Other cases are to the same effect. *See, e.g., Blue Cross Hosp. Serv., Inc. v. Frappier*, 698 S.W.2d 326, 327 (Mo. 1985) (rejecting ERISA preemption challenge to mandated-provider statute based on the insurance savings clause); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D.

Tex. 1995) (holding that any willing provider statute is covered by ERISA's insurance savings clause).

Absent review by this Court, therefore, ERISA plan sponsors and administrators such as respondents and *amici* will continue to be faced with a patchwork of inconsistent state and federal law. In some States, ERISA's broad preemption provision will preclude enforcement of any willing provider statutes against managed-care networks serving employee benefit plans. In other States, by contrast, laws that impose precisely the same regulatory burden on managed-care networks will be immunized from challenge under ERISA, and benefit-plan administrators will therefore be unable to obtain the full benefits of managed care for their plan participants. This Court's review is necessary to eliminate these conflicts and achieve nationwide consistency in the scope of ERISA preemption.

CONCLUSION

With respect to the first question presented, the petition for a writ of certiorari should be granted. In all other respects, the petition should be denied.

Respectfully submitted.

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September 30, 1996

APPENDIX

APPENDIX

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, Montana 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for view on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has

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[2] 15 U.S.C. § 41 *et seq.*

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider

taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these comments have

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Health Care Act of 1983 at 2-3 (October 24, 1983); *Health Care Management Associates*, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition (1977).

[4] *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d. 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982); *Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital of Prince George's County*, 110 F.T.C. 476 (1988); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988); *Medical Staff of Holy Cross Hospital*, No. C-3345 (consent order, Sept. 10, 1991); *Medical Staff of Broward General Medical Center*, No. C-3344 (consent order, Sept. 10, 1991); *see also American Society of Anesthesiologists*, 93 F.T.C. 101 (1979); *Sherman A. Hope, M.D.*, 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. *See e.g.*, Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

addressed "any willing provider" requirements for health care service contracts.[6]

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met

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[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action, the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may pro-

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[8] Mont. Code Ann., § 33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

[9] Mont. Code Ann. § 33-22-1704(3).

vide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not,

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[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. *See*, e.g., J.C. Robinson and C.S. Phibbs, *An Evaluation of Medicaid Selective Contracting in California,* 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences conf irm these findings. *See e.g.*, D. Dranove et al., *Is hospital competition wasteful?* Rand J. Econ., Summer 1992; *see also* G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would

help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can

expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without provided any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirement may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health

care programs, without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

/s/ Michael O. Wise
Michael O. Wise
Acting Director